MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

06671

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: near Annapolis.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #3 R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I.

3.(a) FULL NAME: James Addison Albaugh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary E. Albaugh
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1894

8. AGE: Years	Months	Days	If less than one day
52	7	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: owner Wholesale seafood.
11. Industry or business:
FATHER 12. Name: Harry F. Albaugh
13. Birthplace: Baltimore Maryland
MOTHER 14. Maiden name: Isabelle Addison
15. Birthplace: Baltimore Md.
16. Informant: Carroll Albaugh
Address: R.F.D #3 Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 15 1947 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemt
Location: Baltimore Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. Aug 15 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 13 1947 at 11 A. M.
21. I CERTIFY that death occurred on the date above stated: Post mortem Examination Aug. 14, 1947

	DURATION
Immediate cause of death: Mesenteric embolism	about 36 hours
Due to: Paralytic Ileus.	about 36 hours
Due to: Fracture + Dislocation left shoulder	9 days
Other conditions: Fractured leg	

(Include pregnancy within 3 months of death)

Major findings of operations: Fracture of humerus reduced by pinning in joint. Date of op. Aug. 7, 1947
Autopsy results: Paralytic ileus
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8-5-47
Where did injury occur? Calvert (City or town) Maryland (County) (State)
Injured at home, farm, industry, public place (where?) Route # 416
Means of injury: auto-truck turned Injured at work? yes
23. SIGNATURE: John N. Cleffy M.D. Deputy Medical Ex. amined
M. D. or other
Address: Annapolis, Maryland Date signed 8-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183 B 06672

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Riva
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? several hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3358 Blam St. N.E
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Bruce Aldrich

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Louie Aldrich
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1915

8. AGE:

Years	Months	Days	If less than one day
31	9	2	— hrs. — min.

9. Birthplace D. C. (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Gordon J. Aldrich
FATHER 13. Birthplace Canada
MOTHER 14. Maiden name Sarah Lipscomb
MOTHER 15. Birthplace Washington D.C.
16. Informant Mrs. C. Lathin
Address 102 E. Monroe Ave; Alexandria Va.
17. (Burial, cremation, or removal. Which?) Removal Date thereof Aug (month) 9 (day) 47 (year)
Cemetery or crematory Mt Olivet
Location Washington, D.C.
18. Funeral director Thomas B. Hanlon
Address 641 H St NE. Washington D.C.
19. Aug 9 19 47 Edward Callum Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 19 47 at 6 20 P M
21. I CERTIFY that death occurred on the date above stated, at the time and place and due to the cause stated below.
Post mortem Examination
Aug. 8 19 47

Immediate cause of death	DURATION
Due to Accidental	
Due to Drowning	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accidental Date of 8/8/47
Where did injury occur? Riva (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) South River
Means of injury Drowning Injured at work? no
23. SIGNATURE John M. Clatty M.D Deputy Medical Examiner
M. D. or other
Address Annapolis, Md Date signed 8/8/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

CERTIFICATE OF DEATH

06673

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: —

Hospital, institution, or street address where death occurred:

How long in hospital or institution?: —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chase Home - Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Sue S. Barton

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 20th 1861

8. AGE:

Years	Months	Days	If less than one day
86	5	17	..... hrs: ..... min.

9. Birthplace: Ashland, Virginia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: Howard T. Barton
13. Birthplace: Virginia

MOTHER
14. Maiden name: Frances Washington
15. Birthplace: Virginia

16. Informant: Miss Virginia C Barton

Address: Fuller St. Edgerton - Mass.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8/11/47 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Prince Geo. Co. Maryland

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. Aug. 11 1947 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9, 1947, at 12 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-5-47 1947 to 8-9- 1947 and that I last saw h[illegible] alive on 8-9- 1947

Immediate cause of death	DURATION
Anemia	3 days
Due to Chronic Nephritis	3 yrs
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James R. Martin, M.D.
M.D. or other

Address: 186 Prince George St. Annapolis, Md. Date signed 8-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

06674

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

at residence

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 F Compson St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Era Pearl Bean

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry E. Bean

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): September 29, 1885

8. AGE:

Years	Months	Days	If less than one day
62	10	11	hrs. min.

9. Birthplace: Howard County, Md. (Town, county, and state)

10. Usual occupation: Home

11. Industry or business —

FATHER

12. Name: John Johnson

13. Birthplace: Balto. Co. Md.

MOTHER

14. Maiden name: Alice Foard

15. Birthplace: Balto. Co. Md.

16. Informant: Harry E. Bean

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/12/47 (month) (day) (year)

Cemetery ~~or crematory~~: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis, Md.

19. August 12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 1947 at 2.05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1946 to August 10 1947 and that I last saw h[illegible] alive on August 10 1947

Immediate cause of death	DURATION
Carcinoma of sigmoid	1 yr +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. Kavanaugh, Md. M. D. or other

Address: 31 Smith Gate Ln Date signed: 8/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

128

08698

CERTIFICATE OF DEATH

Reg. Diat. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 12 days

Hospital, Institution, or street address where death occurred: District Training School, Laurel Md

How long in hospital or institution? 1 mo - 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Dist of Col. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1811 Wyoming ave. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Marcia Bean

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 30, 1947

8. AGE:

Years	Months	Days	If less than one day
—	6	12	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: infant

11. Industry or business:

FATHER

12. Name: Mark Bean

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Helen E Garvey

15. Birthplace: Alexandria, Va.

16. Informant: Records of District Training School

Address: Laurel, A.G.Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11-47 (month) (day) (year)

Cemetery or crematory: Mt Olivet Cem.

Location: Wash D.C.

18. Funeral director: Thomas B Hanlon

Address: 641 L St N.E.

19. Aug 10 1947 (Date rec'd by registrar) Clara Kashuk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 1947, at 7.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1947, to Aug 10 1947

and that I last saw her alive on August 10 1947

	DURATION
Immediate cause of death: Congenital Cardiac Anomaly	Life
Due to: Mongolism	Life
Due to:	
Other conditions: Anomaly of pancreas	Life

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James Sewald MD (M.D. or other)

Address: District Training School Date signed: 8/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

30 b

BC 06675

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 10 months, 20 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 year, 10 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 440 W Biddle Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

LILLIE BENTLEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Unknown to us

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown to us

8. AGE: Years	Months	Days	If less than one day
49	?	?	hrs. min.

9. Birthplace: Chesterfield, Virginia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Louis Bentley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mathilda Krummen
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/20/47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt Hospital
Address: Crownsville Md

19. Aug 28 1947 (Date rec'd by registrar) E T Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17th 1947 at 7:35 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28th 1945 to August 17 1947 and that I last saw her alive on August 17 1947

Immediate cause of death: General Paresis Known to us since Sept, 28, 45 — DURATION

Due to:

Due to:

Other conditions: Hypertensive cardio-vascular disease Known to us since Sept. 28, 1945
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Rosenstein M. D.
M. D. or other

Address: Crownsville, Md. Date signed: 8/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 46676

1. PLACE OF DEATH:

County: Old Asbury Road

City or town: Reisterstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Clara Wright Beran

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 28- 1862

8. AGE: Years: 85 Months: 4 Days: 28 If less than one day: hrs. min.

9. Birthplace: Middletown (Town, county, and state) Conn.

10. Usual occupation: Retired music teacher

11. Industry or business:

FATHER — 12. Name: William Wright

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Eunice ?

15. Birthplace: Unknown

16. Informant: Mr. Warren Beran

Address: Asbury Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28 1947 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore Md.

18. Funeral director: William Cook Inc.

Address: 1017 St Paul St.

19. 8-27 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1947, at 5 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947, to Aug 25 1947 and that I last saw her alive on Aug 25-6 1947.

	DURATION
Immediate cause of death: Chronic Myocardial Failure	6 mo
Due to: General debility or Senility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. H. Chilcoat M. D. or other

Address: 3307 Edmondson Ave. Date signed: Aug 26, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06677

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About fifteen minutes
Hospital, Institution, or street address where death occurred:
Station Hospital
How long in hospital or institution? Fifteen minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Baltimore~~
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1317 E. North Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: New Born

3.(a) FULL NAME: THOMAS MICHAEL BOYD

3.(b) Social Security Number: Newborn

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Newborn Infant

6.(b) Name of husband or wife: Newborn Infant
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 26, 1947

8. AGE: Years	Months	Days	If less than one day
-	-	-	..... hrs. 15 min.

9. Birthplace: Fort George G. Meade, Anne Arundel, Md.
(Town, county, and state)
10. Usual occupation: New born
11. Industry or business: -

FATHER
12. Name: S/Sgt Thomas Edward Boyd
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bernadette Rosenauer
15. Birthplace: Maryland

16. Informant: Mrs. Bernadette Boyd (Mother)
Address: 1317 E. North Ave., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sep. 2, 1947 (Month) (day) (year)
Cemetery or crematory: Balto. National
Location: 5708 Frederick Rd.
18. Funeral director: Lilly & Zeiler Inc.
Address: 403 S. Wolfe Street

19. 29 August 47 (Date rec'd by registrar) JAMES N. GOERGER, Capt, MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 19 47 at 1641 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 August 19 47 to 26 August 19 47 and that I last saw him alive on 26 August 1947 19

Immediate cause of death	DURATION
1. Congenital heart with atelectasis, pulmonary	
2. Multiple congenital abnormalities.	
3. Erythroblastosis foetalis	
Other conditions 4. Diaphragmatic hernia with thoracic stomach and spleen	

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.
Autopsy results: Confirmed as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Lowell Peterson
LOWELL F. PETERSON, Capt., M.C. M.D. or other
Address SH, Ft Geo G Meade, Md. Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66678

Reg. Dist. No. 28

1. PLACE OF DEATH: Anne Arundel
County: Crownsville, Maryland
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years, 2 months, 24 days
Hospital, Institution, or Street address where death occurred: Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 5 years, 2 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (If nonresident, give residence of mother)
State: Maryland County: Ware.
City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. # 2 (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ALBERT BRITTINGHAM

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1915
8. AGE: 32 years Months Days If less than one day hrs. min.
9. Birthplace: Maryland (City or town, and state)
10. Usual occupation: Farm Laborer
11. Industry or business:
FATHER 12. Name: Henry Brittingham
13. Birthplace: Maryland
MOTHER 14. Maiden name: Catherine Purnell
15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/18/47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt of Hospitals
Address: Crownsville Md.
19. Aug 18 1947 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1947 at 3:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1942 to August 6 1947 and that I last saw him in August 6th 1947 and that I last saw h alive on 19

Immediate cause of death: Tuberculosis of left Hipjoint Known to us since May 26, 47 DURATION

Due to:

Due to: Mental Deficiency without Psychosis Known to us since May 13, 42

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern (M.D.)
Address: Crownsville, Maryland M. D. 8/8/47
Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92c

06679

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft. George G. Meade
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Ft. Meade Regional Hospital

How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Raynor Heights (Linthicum P.O.)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Nursery Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: THEODORE BURKOWSKE

3.(b) Social Security Number: 215 10 9219

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Burkowske Nee Dryer

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): August 29, 1907

8. AGE: Years	Months	Days	If less than one day
39	11	18	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Wood Worker

11. Industry or business: Jute Craft Mfg. Co.

FATHER
12. Name: Charles Burkowske
13. Birthplace: Germany.

MOTHER
14. Maiden name: Margaret Kroener
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Margaret Burkowske
Address: Nursery Rd. (Linthicum Hts. R.F.D.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 19, 1947 (month) (day) (year)
Cemetery or crematory: Louden Park
Location: Baltimore, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 16 August 1947 (Date rec'd by registrar) WILLARD A. ALEX, Capt., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16, 1947, at 9.35P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12 Aug 1947, to 9:35 P.m 16 Aug 1947 and that I last saw h.imi alive on 16 Aug 47 at 9:35 P.M 19....

Immediate cause of death	DURATION
(a) Pulmonary embolism	
Due to (b) Aortic insufficiency	
Due to (c) Rheumatic Fever	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No Operations Date of op.

Autopsy results: Aortic stenosis, Pulmonary embolism

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul E. Sieber Lt. M.C.
M. D. or other

Address: 210th Hosp. F.D.S.R.M. Date signed: 16 Aug 47

06680 8.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 848

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 6 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1126 N. Carrollton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME BYRD - GOLDON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Annie Byrd
6.(c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Unknown to us 1903

8. AGE: Years	Months	Days	If less than one day
44	?	?	hrs. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual occupation Barber
11. Industry or business
FATHER 12. Name Goldon Byrd, Senior
13. Birthplace South Carolina
MOTHER 14. Maiden name Annie Bell
15. Birthplace South Carolina
16. Informant Hospital Records
Address Crownsville State Hospital, Maryland
17. Burial Date thereof 8 - 11 - 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory ~~Cemetery~~. ~~Mount Calvert~~
Location ~~Anne Arundel County~~ Winnsboro, S.C.
18. Funeral director Charles H. Alexander
Address 1200 N. Mullow St. Balto
19 8/19 19 47 O. W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 19 47, at 3:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 19 47, to August 8 19 47
and that I last saw him alive on August 8 19 47

Immediate cause of death	DURATION
Schizophrenia, Catatonic Type	Known to us since Jan. 27, 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Jacob Morgenstern M. D.
M. D. or other
Address Date signed

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06681

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:
Old Town Rd. Woodland Beach

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Town Rd. - Woodland Beach
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sylvia Capannelli ~~Capannella~~

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Ignatius Capannelli

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): April 7, 1876

8. AGE: Years	Months	Days	If less than one day
71	4	23	....hrs. ....min.

9. Birthplace: Italy (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Giannini
13. Birthplace: Italy

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Ignatius Capannelli
Address: Woodlawn Beach A26 Md.

17. (Burial, cremation, or removal. Which?) Removal Date thereof Aug 10 1947 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location

18. Funeral director: W W Chamberlain Co.
Address 517 - 11th St Washington D.C.

19. Aug. 10 1947 (Date rec'd by registrar) Edward Callmeyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10 1947, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19.... to 19....

and that I last saw h... alive on ... attended by Dr. D. N. Hooker

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: coronary occlusion	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: E. Preston Ritchings, M.D.
M. D. or other

Address: Annapolis, Md. Date signed: Aug. 10, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

06682

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel -

City or town: Harwood. Md. -

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 months

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna County:

City or town: Philadelphia

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lincoln Drive, Johnson St. Penna.

(If rural, give LOCATION)

2.(a) If veteran, name war: none ✓

3.(a) FULL NAME: Sidonia Riess Chesten -

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(c) If alive, give age: years

8.(b) Name of husband or wife: James Chesten 3rd.

7. Birth date of deceased (mo., day, yr.): April 9 1885

8. AGE: Years	Months	Days	If less than one day
62	4	3	hrs. min.

8. Birthplace: Bucharest, Roumania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Emmanuel Reiss

13. Birthplace: Bucharest, Roumania

MOTHER — 14. Maiden name: Tino CRASS

15. Birthplace: Bucharest Roumania

18. Informant: Robert M. Chesten

Address: 428 Wellesley Road. Phila. 19 Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13 1947 (month) (day) (year)

Cemetery or crematory: Christ Church

Location: West River, Md.

18. Funeral director: T. A. Hardesty & Son

Address: Edgewater Md

19. 8/12 47 (Date rec'd by registrar) W. C. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1947 at 6.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 1947, to August 12 1947

and that I last saw h.e alive on August 11th 1947

Immediate cause of death	DURATION
a. Cerebral hemorrhage	
Due to: Hypertension —	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Emil H. Nilsen, M.D. M. D. or other

Address: Centreville, Md. Date signed: 8/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Allen

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06683

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Ann Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 83 Water Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Madoline Chew

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 10, 1913

8. AGE: Years	Months	Days	If less than one day
34	8	2	..... hrs. ..... min.

9. Birthplace Ann Arundel, Annapolis, Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business

FATHER
12. Name Madoline- John Chew
13. Birthplace South River, Md.

MOTHER
14. Maiden name Annie Wright
15. Birthplace A.A.Co, Md.

16. Informant Annie Chew
Address Spa Road. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 15, 1947 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis, Md

18. Funeral director J.B. Johnson
Address Annapolis, Md. P.O. Box 462

19. Aug. 15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-47 19 ..... at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-22 1946 to 8-12 1947 and that I last saw h[illegible] alive on 8-11-47 19 .....

Immediate cause of death	DURATION
(a) Hypostatic Pneumonia	
Due to (b) Lymphogranuloma	
Due to (c) Lymphosarcoma Inguinale	
Due to (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A.T. Allen M.D.
M. D. or other
Address 17 Carroll St. Date signed 8-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 BE

P. 06684

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Anne Arundel
City or town SEVERNA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 MONTHS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 426 E. 20TH ST.
(If rurel, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME JAMES BENJAMIN CRAFTON SR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife HENRIETTA
6.(c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) MAY 20, 1861

8. AGE: Years	Months	Days	If less than one day
86	3	6	.....hrs. .....min.

9. Birthplace URBANA, VIRGINIA (Town, county, and state)
10. Usual occupation BLACKSMITH
11. Industry or business J.F.W. DORMAN CO.
FATHER 12. Name JAMES L CRAFTON
13. Birthplace VIRGINIA.
MOTHER 14. Maiden name MARY SOOTH
15. Birthplace VIRGINIA.
16. Informant HENRIETTA CRAFTON
Address SEVERNA PARK, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/29/47 (month) (day) (year)
Cemetery or crematory Lorraine Cem.
Location Balto Co.
18. Funeral director Wm Cook Jr
Address 1217 St Paul St
19. 8/28 1947 (Date rec'd by registrar) A.W. Tedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1947, at 1158 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1945 to Aug. 20, 1947 and that I last saw h. alive on Aug 26, 1947

Immediate cause of death	DURATION
Myocardial insufficiency	2 yrs.
Due to	
Due to	
Other conditions General arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Willis Grayton M.D. M. D. or other
Address 3963 Greenmount Ave Date signed 8/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Klawans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06685

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)
Street No.: 131 Chester Avenue (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Edward Crowdy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Anna Crowdy
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 18, 1896

8. AGE:	Years	Months	Days	If less than one day
	50	7	17	hrs. min.

9. Birthplace: Eastport, A.A.Co., Md. (Town, county, and State)
10. Usual occupation: Oysterman
11. Industry or business:
FATHER 12. Name: James Crowdy
13. Birthplace: Md.
MOTHER 14. Maiden name: Isabelle Maurray
15. Birthplace: Md.
16. Informant: Laura Harris
Address: 131 Chester Ave. Eastport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 7, 1947 (Month) (day) (year)
Cemetery or crematory: Annapolis Neck
Location: Annapolisneck, Md.
18. Funeral director: J.B.Johnson
Address: Annapolis, Md.
19. Aug. 7, 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4 1947, at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1947, to Aug 4 1947
and that I last saw h[illegible] alive on Aug 1 1947

Immediate cause of death	DURATION
Chr. Myocarditis & Hemp.	
Due to: Aortic & Mitral insuf.	
Due to: Late Lues.	
Other conditions: Probably Pulmonary Tbc	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. J. Klawans M. D. or other
Address: 31 Southgate Ave. Date signed 8/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06686

97

BC

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years, 3 months, 3 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Maryland

How long in hospital or institution? 11 years, 3 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 756 Dolphin Street
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3. (a) FULL NAME

FERDINAND DEAVER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ~~Unknown to us~~ 1883

8. AGE: Years	Months	Days	If less than one day
64	?	?	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: George Deaver

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Moquette

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/18/47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

16. Funeral director: Ralph Hospital

Address: Crownsville Md

19. Aug 15 47 (Date rec'd by registrar) E.F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9th 19 47 at 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 39, to August 9th 19 47

and that I last saw h im alive on August 9 19 47

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Known to us since	
May 6th, 1936	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Moquette M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 8/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06687

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years

Hospital, Institution, or street address where death occurred: # 214 D. st., S.W.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 214 D. Street S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RUBIN MONROE DONALDSON

3.(b) Social Security Number: 215 01 6688

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie Donaldson Nee Vogt

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): September 6, 1880

8. AGE: Years	Months	Days	If less than one day
66	10	8	....hrs. ....min.

9. Birthplace: Severn, Anne Arundel Co., Md. (Town, county, and state)

10. Usual occupation: General Labor (Retired)

11. Industry or business

FATHER 12. Name: David E. Donaldson

13. Birthplace: Anne Arundel Co., Md.

MOTHER 14. Maiden name: Elizabeth Shipley

15. Birthplace: Anne Arundel Co., Md.

16. Informant: Mrs. Lillian Donaldson

Address: 214 D. St.S.W., Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 18, 1947 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 8/16/47 (Date rec'd by registrar) M. R. Dallas Registror

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14, 1947, at 7.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/9/47 19.... to 8/14/47 19.... and that I last saw h.... alive on 8/13/47 19....

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 DAY
Due to: Arteriosclerosis	
Due to: Chronic Interstitial Nephritis	UNKNOWN
Due to: Endocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. Kirk Commander M. D. or other

Address: Glen Burnie, Md. Date signed: 8/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

06688

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Marley - (Marley Creek)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Glen Burnie, Route #2
(If outside city or town limits, write RURAL and give nearest town)
Street No. Marley Neck Road
(If rural give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Howard Edwards

3.(b) Social Security Number

4. Sex male
5. Color or race negro
6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 5. 1930
8. AGE: Years 17 Months 1 Days 9 If less than one day ... hrs. ... min.
9. Birthplace Marley, A.A., Maryland (Town, county, and state)
10. Usual occupation Labor
11. Industry or business Construction work
FATHER 12. Name James Rufus Edwards
13. Birthplace Marley, Maryland
MOTHER 14. Maiden name Pearl L. Pitts
15. Birthplace Marley, Md
16. Informant James R. Edwards
Address Route #2, Marley Neck Rd. Glen Burnie Md
17. Burial Date thereof 8/17/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Marley Neck et
Location A. A. Co. Md
18. Funeral director Isaiah L. Brown & Son
Address
19. 8/16 1947 M. R. D. Allen Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1947 at 3P. M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~
Postmortem Examination 19
~~...~~ Aug 16 1947.

Immediate cause of death	DURATION
Accidental	
Due to	
Drowning	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of Aug 14 1947
Where did injury occur? Marley Creek, A.A., Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Marley Creek
Means of injury drowning Injured at work? No.
23. SIGNATURE John M. Caffy, M.D., Deputy medical Examiner
M. D. or other
Address Annapolis, Md. Date signed 8-16-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06689

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Maryland

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 634 W. Lafayette
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: MARY GALLOWAY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 12, 1930

8. AGE: Years	Months	Days	If less than one day
17	5	28	hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER
12. Name: John Galloway
13. Birthplace: W. Virginia

MOTHER
14. Maiden name: Celestine Wood
15. Birthplace: W. Virginia

18. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11 1947 (month) (day) (year)

Cemetery or crematory: Shipped to

Location: Charlestown, W. Va.

18. Funeral director: J. B. Johnson

Address: Annapolis Md.

19. Aug. 11 1947 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9th 1947, at 5:05A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25th 1947 to August 9th 1947 and that I last saw her alive on August 9th 1947

Immediate cause of death: GENERAL PARESIS — DURATION: Known to us since July 25, 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M. D.
M. D. or other

Address: Crownsville, Maryland Date signed: 8/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06690

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Ann Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 100 Smithville (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ~~Infant~~ Galloway, Vermont Selden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 27, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	2	..... hrs. ..... min.

9. Birthplace: Annapolis, Md. A.A.Co.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Vermont Galloway

13. Birthplace: Annapolis, Md.

MOTHER — 14. Maiden name: Bettie Wallace

15. Birthplace: California

16. Informant: Mrs. Charles Tyler

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30, 1947 (month) (day) (year)

Cemetery or crematory: Asbury [illegible]

Location: Annapolis, Md.

18. Funeral director: Annie A. Johnson

Address: Annapolis, Md. P.O. Box 462.

19. Aug. 30 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-29 1947, at 7:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-27 1947 to 8-29-47 19

and that I last saw h[illegible] alive on 8-29-47 19

Immediate cause of death	DURATION
aspiration pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 17 Carroll St Date signed: 8-29-47

YS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

552

06691

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital, Annapolis, Maryland

How long in hospital or institution? One month, four days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 49 Murray Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: GESSNER, Frank Richard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Wife: Mrs. Hilma May Gessner

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): January 26, 1884

8. AGE: Years	Months	Days	If less than one day
63	6	28	...hrs. ...min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation: U.S.Navy

11. Industry or business: Retired

FATHER
12. Name: Frank J. Gessner
13. Birthplace: Philadelphia, Penn.

MOTHER
14. Maiden name: Ann T. Clark
15. Birthplace: England

16. Informant: Wife: Mrs. Hilma May Gessner
Address: 49 Murray Avenue, Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 27 August 1947 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetry

Location: Annapolis, Maryland

18. Funeral director: B.L. Hopping & Son

Address: Annapolis, Maryland

19. Aug. 26, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 August 1947, at 7:41 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 July 1947, to 24 August 1947 and that I last saw him alive on 24 August 1947

Immediate cause of death	DURATION
Anemia, Secondary	
Due to: Sarcoma, Melano Generalized	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Richard S. Farr M.D.
M. D. or other

Address: U.S. Naval Hospital Date signed: 8/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Richardson.

06692

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Annapo Arundel
City or town Sudley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Sudley
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Henry Gray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Annie Gray

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 12, 1874.

8. AGE: Years	Months	Days	If less than one day
73	7	24	..... hrs. ..... min.

9. Birthplace: Calvert Co.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Thomas Gray
13. Birthplace: Calvert Co.

MOTHER
14. Maiden name: Alberta Chiles
15. Birthplace: Calvert Co.

16. Informant: Annie Gray
Address: Sudley P.O., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 13, 1947 (month) (day) (year)
Cemetery or crematory: Chews
Location: Owensville, Md.

18. Funeral director: J.B. Johnson
Address: Annapolis, Md.

19. Aug. 12 1947 (Date rec'd by registrar) W.L. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1947 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8, 1947, to August 9, 1947 and that I last saw him alive on August 9, 1947

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage	2 Days.
Due to (b) Arteriosclerosis	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H.L. Richardson M.D. M. D. or other
Address 110 - Clay St. Date signed 8/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06693 P

848

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 621 W. Saratoga
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: ROBERT HALEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Luvina

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 25. 1905

8. AGE: Years	Months	Days	If less than one day
42	?	?	hrs. min.

9. Birthplace: Unknown to us
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER
12. Name: ?
13. Birthplace:

MOTHER
14. Maiden name: ?
15. Birthplace:

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 8/17/47 (month) (day) (year)
Cemetery or crematory: Hollywood Cemetery
Location: Elizabeth City, N. C.

18. Funeral director: William A. Jackson
Address: 916 Penna. Ave, Balto 1, Md.

19. August 15 19 47 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 19 47 at 1:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9 19 47 to August 13 19 47 and that I last saw him alive on August 13 19 47

Immediate cause of death	DURATION
Catatonic Stupor, Schizophrenia	
Known to us since	
Due to: August 9, 1947	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morycuster M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 8/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 21

06694

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A A.
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William H. Hall II

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 14th 1947

8. AGE: Years | Months | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name William H. Hall
13. Birthplace Calvert Co Md.

MOTHER
14. Maiden name Marie Rogers
15. Birthplace Annapolis Md.

16. Informant William H. Hall
Address Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18th 1947 (month) (day) (year)
Cemetery or crematory Edwards Chapel
Location Parole Md.

18. Funeral director John M. Taylor, Son
Address Annapolis Md.

19. August 18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16th 1947, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14th 1947 to Aug 16 1947 and that I last saw him alive on Aug 16th 1947

	DURATION
Immediate cause of death	
Premature	2 3/4 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Boyd M. D. or other
Address Annapolis Md. Date signed 8-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

06695

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Q A.

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William H. Hall III

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14th 1947

8. AGE: Years | Months | Days | If less than one day: 8 hrs. min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name William H. Hall

13. Birthplace Calvert Co. Md.

MOTHER 14. Maiden name Marie Rogers

15. Birthplace Annapolis Md

18. Informant William H. Hall

Address Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18th 1947 (month) (day) (year)

Cemetery or crematory Edwards Chapel

Location Pasadena Md.

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. August 18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14th 1947, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14th 1947 to Aug 14th 1947

and that I last saw him alive on Aug 14th 1947

Immediate cause of death	DURATION
Premature	3 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boyd M. D. or other

Address Annapolis Date signed 8-18-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

06696

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Raynor Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 hr
Hospital, institution, or street address where death occurred: Eugene's Wilbur Grove - Hammonds Ferry Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town N. Linthicum
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4 Eleanore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carl John Heinsitz

3.(b) Social Security Number 218-07-9956

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife May V. Bowersox

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 9/21/93

8. AGE: Years	Months	Days	If less than one day
53	10	17	hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Rigger (Retired)

11. Industry or business

FATHER 12. Name George Heinsitz

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Lena M. Hashagen

15. Birthplace Baltimore, Md.

16. Informant George O. Heinsitz (son)

Address North Linthicum (Linthicum Md. P.O.)

17. Burial (Burial, cremation, or removal) Which?) Date thereof Aug. 11, 1947 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18. Funeral director James D. Singleton

Address Glen Burnie, Md.

19. 8/11/1947 (Date rec'd by registrar) M. R. Dralle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7th 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of .....

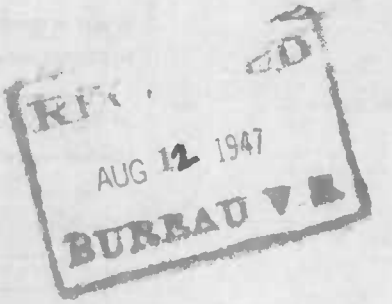
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury — Injured at work? —

23. SIGNATURE Gustave A. Faubert M.D. attending deputy medical examiner M. D. or other

Address Glen Burnie Md Date signed 8/7/47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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06697

183

File No. G 112 AUG 25 1947

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Herald Harbor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Severn River

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2605 4th North St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME: John D. Herbert

3.(b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 23d 1879

8. AGE: Years: 67 Months: 11 Days: 21 If less than one day: hrs. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: Elevator Man

11. Industry or business: Cairo Hotel

FATHER 12. Name: Frederick L. Herbert

13. Birthplace: Balto. Md.

MOTHER 14. Maiden name: Virginia Huff

15. Birthplace: Va

16. Informant: Mrs John H. Rowe

Address: 612 E. Biddle St. Balto Md.

17. Burial, cremation, or removal. Which?: Burial Arlington Va Date thereof: Aug 19th 1947 (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Arlington Va

18. Funeral director: W. W. Chambers

Address: Washington D. C.

19. August 15 1947 (Date rec'd by registrar) W. W. Chambers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 14 19 47 at 10 50 M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19

and ~~that I last saw him~~ alive on 19

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Accident Date of: Aug. 14, 1947

Where did injury occur? Herald Harbor (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Public place

Means of injury: Drowned Injured at work?

23. SIGNATURE: E. Leyton Ritchings, M.D. M. D. or other

Address: Annapolis, Md. Date signed: Aug. 14, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

66698

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessup Md. R.F.D. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years.
Hospital, Institution, or street address where death occurred: Montevideo
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Jessup R.F.D #1 (If outside city or town limits, write RURAL and give nearest town)
Street No.: Montevideo Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: IDA V. Higgs.

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Milton M.
6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): July 25, 1873

8. AGE:

Years	Months	Days	If less than one day
74	0	7	....hrs. ....min.

9. Birthplace: Montevideo, A.A. Co. Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home.

FATHER
12. Name: Henry Marks.
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Bennett
15. Birthplace: Montevideo, A.A. Co. Md.

16. Informant: Leslie M. Higgs.
Address: Montevideo, Jessup, A.A. Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5, 1947 (month) (day) (year)
Cemetery or crematory: Zion
Location: Dorsey Md.

18. Funeral director: Thomas W. Pangaton
Address: Glen Burnie, Md.

19. 8/4 1947 (Date rec'd by registrar) KWS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1947 at 6.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1947 to Aug. 2 1947 and that I last saw h[illegible] alive on July 30 1947

Immediate cause of death: Coronary Occlusion — DURATION: Instant.
Due to: Hypertensive Cardio-Vascular Disease — DURATION: 1 yr.
Due to:
Other conditions: ✓

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley, M.D. M. D. or other
Address: Savage, Md. Date signed: 8/3/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Johnson

06699

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 26

Item 32 Film D213 4/4/57

1. PLACE OF DEATH:
County Ann Arundel
City or town Shadyside, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Shadyside, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Albert Jacob ~~Alfred~~ Holland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary E. Holland
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) C Oct., 28, 1870.

8. AGE: Years	Months	Days	If less than one day
76	10	15	....hrs. ....min.

9. Birthplace C Churchton Md., A.A. Co.
(Town, county, and state)
10. Usual occupation Oysterman
11. Industry or business
FATHER 12. Name James H. Holland
13. Birthplace A.A.Co.
MOTHER 14. Maiden name Jane Dennis
15. Birthplace A.A.Co.
16. Informant Mary E. Holland
Address Shadyside, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 16, 1947 (month) (day) (year)
Cemetery or crematory Family Cemetery
Location Shadyside, Md.
18. Funeral director J.B. Johnson
Address Annapolis, Md. P.O. Box 462
19. August 16 19 47 J. B. Dent. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1947 at 2:00A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1947, to Aug. 13, 1947 and that I last saw him alive on August 13, 1947

Immediate cause of death	DURATION
Diabetic Coma	2weeks
Due to Diabetis Mellitus	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. B. Johnson M.D. M. D. or other
Address 40 Northwest Street Date signed Aug. 15, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

7509

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: County Prince George Anne Arundel

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Davis' Residence, Old Fort Meade, Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Arlington

City or town Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3520 S. Stafford St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME DAVID STEPHEN HOWE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife NONE

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 9, 1947

8. AGE: Years 0 | Months 3 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Allen K. Howe

13. Birthplace Red Wing, Minn.

MOTHER 14. Maiden name E. LaVerne Hoestrom

15. Birthplace Axtel, Kansas

16. Informant Allen K. Howe

Address 3520 S. Stafford St. Arl. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 22, 1947. (month) (day) (year)

Cemetery or crematory

Location Red Wing, Minn.

18. Funeral director J. Arthur Walters

Address 505 Washington Blvd., Laurel, Md.

19. Aug 19 1947 (Date rec'd by registrar) Clara Haslich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Aug 47 1947, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 May 47 19.. to 19 Aug 1947

and that I last saw him alive on 3 July 1947

Immediate cause of death	DURATION
Due to Malnutrition, dysentery, intestinal obstruction due to	
Due to abdominal mass. Hydrocephalus, meningocele.	
Other conditions Spina bifida and numerous other anomalies.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John W. Peacock M.D.

M. D. or other

Address 1501 N. St NW Wash DC Date signed 19 Aug 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

06710

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
Johnson Maternity Clinic
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.C.
City or town: Galesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Baby Jackson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 29 1947

8. AGE: Years | Months | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Annapolis AA. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: William Jackson
13. Birthplace: Fairhaven Md.

MOTHER
14. Maiden name: Helen Easton
15. Birthplace: Galesville Md.

16. Informant: William Jackson
Address: Galesville. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: SEPT 1, 1947 (month) (day) (year)
Cemetery or crematory: Daniel Stair
Location: West River

18. Funeral director: T. A. Hardesty
Address: Galesville. Md.

19. Sept. 1, 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30, 1947, at 8:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29, 1947, to August 30, 1947 and that I last saw him alive on August 30, 1947

Immediate cause of death	DURATION
Pneumonia, Bronchial (9/24/47 os)	2 days
Due to	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Theodore F. Johnson M.D.
M. D. or other
Address: 40 Northwest Street Date signed: 8/30/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

06701

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 59 College Creek Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edgar Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Priscilla Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 22, 1900

8. AGE: Years	Months	Days	If less than one day
46	8		..... hrs. ..... min.

9. Birthplace: Annapolis, A.A.Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: E Edgar Johnson
13. Birthplace: A.A.Co.
MOTHER 14. Maiden name: Priscilla Johnson
15. Birthplace: A.A.CO. Md.
16. Informant: Lottie [illegible] Johnson
Address: 59 College Creek Terrace
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 25, 1947 (Month) (day) (year)
Brewer Hill
Cemetery or crematory
Location: Annapolis, Md.
18. Funeral director: Annie A. Johnson
Address: Annapolis, Md.
19. Aug. 25 1947 (Date rec'd by registrar)
[signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1947, at 11 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1947, to Aug 22 1947 and that I last saw h[illegible] alive on Aug 22 1947

Immediate cause of death	DURATION
Status Asthmaticus	2 wks.
Due to: Bronchial asthma	
Due to: allergic.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. J. Klavans, Md M. D. or other
Address: 31 Southgate Av Date signed: 8/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

06703

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 505 Greenwood Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MARY JULIA MATELING

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry B. Mateling

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): February 12, 1875

8. AGE: Years	Months	Days	If less than one day
71	6	8	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER

12. Name: Frank Jendrek

13. Birthplace: Germany

MOTHER

14. Maiden name: ----- Trafalgus

15. Birthplace: Germany

16. Informant: Miss Virginia Mateling

Address: 505 Greenwood Rd. Linthicum, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 23, 47 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 8/22/47 (Date rec'd by registrar) M. R. Oakley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 19 47, at 8.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 36, to Aug 20 19 47

and that I last saw h[er] alive on Aug 20 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis - Malignant Hypertension	6 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Ball Jr. M.D. M. D. or other

Address: Linthicum Date signed 8-20-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06702

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County A. A. Co
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto Brooklyn
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3709 8th St Balto Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Quinten J. McDonald.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Wi.

6.(b) Name of husband or wife Ruth McDonald
6.(c) If alive, give age 24 years
7. Birth date of deceased (mo., day, yr.) May 25, 1922

8. AGE: Years	Months	Days	If less than one day
25	2.		hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual occupation Auto Machinist
11. Industry or business
FATHER 12. Name Valey McDonald
13. Birthplace Pennsylvania
MOTHER 14. Maiden name Madeline McMullen
15. Birthplace Pennsylvania
16. Informant Ruth McDonald
Address 3709 8th St Balto Md
17. Removal Date thereof Aug 18th 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Baltimore Md
18. Funeral director Martin J. Conroy
Address 1600 Holland St Balto Md.
19. August 18, 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1947, at 3:00 A.M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19
~~and that I last saw h~~ alive on 19

Immediate cause of death	DURATION
Transection of spinal cord	
Due to fracture of cervical vertebra	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Aug. 18, 1947
Where did injury occur? West Annapolis A. A. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public place
Means of injury Car ran into water Injured at work? No

23. SIGNATURE E. Peyton Ritchie, M.D.
M. D. or other
Address Annapolis, Md. Date signed Aug. 18, 1947

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06704 P

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A. Co. Md.
City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 Hammonds Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Dianna M. Mitchell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Herman Mitchell
6.(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Sept. 17- 1923

8. AGE: Years 23 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Long Island N. Y.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Jack Stevens
13. Birthplace Chicago Ill.

MOTHER
14. Maiden name Anna Stankovich
15. Birthplace —

18. Informant Herman Mitchell
Address 515 Hammonds lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-10-1947 (month) (day) (year)
Cemetery or crematory New York
Location N.Y.

18. Funeral director Flynn & Flannigan
Address 1476 Light St.

19. 8/9 1947 (Date rec'd by registrar) A W Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1946 to Aug 7 1947
and that I last saw h. alive on Aug 7 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis for advanced	1 Yrs.
Due to Tubercle bacilli	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. J. Siegel M.D
M. D. or other
Address Asst. Wilson, Md. Date signed 8/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06705

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County A. A. County

City or town Greenland Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A. A.

City or town Greenland Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No. Curtis Bay P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bessie M. Morrissett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband or wife Richard M. Morrissett

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 7, 1891

8. AGE: Years 56 Months Days If less than one day hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Balto. Md.

MOTHER 14. Maiden name unknown

15. Birthplace Balto. Md.

16. Informant Richard M. Morrissett

Address Greenland Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 8, 1947 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Patchin Highway

18. Funeral director Keane Funeral Home

Address 1216 E. Charles St.

19. Aug 7 1947 (Date rec'd by registrar) C. A. Wedel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 1947, to August 5 1947

and that I last saw her alive on August 5 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to	
Due to	
Other conditions Hypertensive Cardio-Vascular Disease (Include pregnancy within 3 months of death)	

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Brady Smith M.D. M. D. or other

Address Riviera Beach, Md. Date signed 8/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

06706

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 years
Hospital, institution, or street address where death occurred: 15 Monument St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 15 Monument
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Sarah Parker

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: James Walter Parker
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): September 1891

8. AGE: Years	Months	Days	If less than one day
55	11		____ hrs. ____ min.

9. Birthplace: Annapolis A. A. Co. Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Charles Queen
13. Birthplace: A. A. Co. Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Viola Walker
Address: 73 Pleasant St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 11-47 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West St. Ext.
18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St Annapolis Md.
19. Aug. 11, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 8 19 47 at about 1.30 P. M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination. ~~and that I last saw h~~ alive on Aug. 8 19 47

Immediate cause of death	DURATION
Withheld for further investigation	
Due to: Cerebral hemorrhage	
Due to: Arteria sclerosis	
Other conditions: 10/22/47-AS	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner. (M. D. or other)
Address: Annapolis Md. Date signed 8/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If not known, so state. Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160a

06707

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A A
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 514 Second St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Baby Girl Parks; Linda Elaine

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 31st 1947

8. AGE: Years ____ Months ____ Days 4 If less than one day ____ hrs. ____ min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Lawrence E. Parks
13. Birthplace: Eastport Md.

MOTHER
14. Maiden name: Helen Violette Whitacher
15. Birthplace: West Va

16. Informant: Lawrence E. Parks
Address: Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 6th 1947 (month) (day) (year)

Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Day Co. Inc
Address: Annapolis Md

19. August 6, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

(CB) 11:53 A.M.

20. DATE OF DEATH: 8-4- 1947, at 11:53 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-1- 1947, to 8-4 1947 and that I last saw h. alive on 8-4 1947

Immediate cause of death	DURATION
Intracranial Hemorrhage	
Due to: Birth Injury	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Eastport Md Date signed 8/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06708 P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? less than 24 hours
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? less than 24 h

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1203 Younger Court
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: ALPHA PEAY

3.(b) Social Security Number: .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	M

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: unknown — years
7. Birth date of deceased (mo., day, yr.): unknown appar 33

8. AGE: Years: ~~Unknown~~ 33 (appar) | Months: unknown | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Record
Address: CROWNSVILLE

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/23/47 (month) (day) (year)
Cemetery or crematory: .....
Location: Winston Salem N.C.

18. Funeral director: Elroy C. Wilson
Address: 1000 Brantley Ave

19. 8-20 19 47. G. W. Hyland Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: august 19 1947, at 11 A M

21. I CERTIFY that death occurred on the date above stated; ~~and that I last saw deceased on~~ Post Mortem Examination on Aug. 19, 1947

	DURATION
Immediate cause of death: Acute Cardiac Failure	sudden
Due to: Edema of Lungs	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Leahy M.D. Deputy Medical Examiner
M. D. of other
Address: Annapolis, Md. Date signed 8/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06709

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Shadyside (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: AnnArundel

City or town: Shadyside (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alverta Rebecca Smallwood Powell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Charles Powell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1914

8. AGE: Years	Months	Days	If less than one day
33	2	10	hrs. min.

9. Birthplace: Shadyside, A.A.Co. Md. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER — 12. Name: Chesterfield Coates

13. Birthplace: A.A.Co.

MOTHER — 14. Maiden name: Rachiel Brown

15. Birthplace: A.A.Co.

16. Informant: Charles Powell

Address: Shadyside, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 19, 1947 (month) (day) (year)

Cemetery or crematory: St. Mathews

Location: Shadyside, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis, Md. P.O. Box 462

19. August 19, 1947 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-16-47, 19..., at 4.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-16-47, 19..., to 8-16-47, 19...

and that I last saw h... alive on 8-16-47, 19...

Immediate cause of death: Carcinoma of Stomach — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: G. T. Talley M.D. M. D. or other

Address: 17 Carroll St. Date signed: 8-18-47

VS A-15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06710

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, Institution, or street address where death occurred: HO Fleet St. Annapolis Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. HO Fleet St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Sarah Price

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: George Price
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: 70 Months: Days: If less than one day: hrs. min.

9. Birthplace: Shadyside Anne Arundel Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: none

FATHER
12. Name: Samuel Wiggs
13. Birthplace: Prince George County

MOTHER
14. Maiden name: Catherine Parker
15. Birthplace: Shadyside A.A. Co. Md

16. Informant: Mrs Catherine Price
Address: HO Fleet St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-14-47 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Rtd.

18. Funeral director: Mrs Charles B. Hicks
Address: 45 Northwest St Annapolis Md.

19. Aug. 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1947 at 2:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1946 to August 10 1947 and that I last saw her alive on August 10, 1947

Immediate cause of death	DURATION
Cardiac Failure	6 Mons.
Due to: Hypertensive Cardio Vascular Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 40 Northwest St. Annapolis Md. Date signed 8/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

06711

Reg. Dist. No. 2C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Dorsey - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Rural Dorsey Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 1/2 miles north

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emily Jane Pumphrey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	widowed

6.(b) Name of husband or wife: Merrick Pumphrey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 26, 1884

8. AGE: Years 63 | Months 1 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Pindell, Md (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William Owens

13. Birthplace: A.A. Co.

MOTHER — 14. Maiden name: Sarah Butler

15. Birthplace: Anne Arundel Co.

16. Informant: Mary Wilson

Address: 1500 42nd Place N.W. Wash. D.C.

17. Burial, cremation, or removal. Which?: Burial Lot #3 Date thereof: Aug. 14 1947 (month) (day) (year)

Cemetery or crematory: Moses Cem.

Location: Dorsey Md

18. Funeral director: W. E. Hopkins & Son

Address: Galesville Md.

19. (Date rec'd by registrar) 8/12 47 19 W. E. Clayton Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 August 1947 at 3 5/ PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Mar 1947 to 10 Aug 47 19

and that I last saw h.r alive on 10 Aug 47 19

	DURATION
Immediate cause of death: Congestive Heart Failure	2 mos
Due to: Carcinoma of left breast & multiple metastases	3 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert B. Jones M. D.

Address: Upper Marlboro Md Date signed: 11 Aug 47

66712

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? one hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RFD # 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN HENRY PURDHAM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: Margaret M Purdham
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): June 22, ~~1879~~ 1879

8. AGE:

Years	Months	Days	If less than one day
68	1	25	...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Margaret M. Purdham
Address: Gambrills, RFD Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20, 1947 (month) (day) (year)
Cemetery or crematory: Glen Hamen Memorial Cemetery.
Location: Glen Burnie, Maryland
18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland
19. ...19... (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 1947, at 1.40 M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 6, 1945 to Aug. 17 1947
and that I last saw h... alive on Aug. 17 1947
Immediate cause of death: Acute Myocardial failure — DURATION: 1 hour
Due to: Chronic myocarditis — 2 years
Due to: Diabetes Mellitus — unknown
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Claffey M.D.
M. D. or other
Address: Annapolis, Md. Date signed 8/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

66713

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Annapolis Wd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? Since 8/8/47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Gambrills - Wd

(If outside city or town limits, write RURAL and give nearest town)

Street No.: (None)

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Elizabeth Rawlings

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Married

6.(b) Name of husband or wife: Roland Rawlings

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): April 14 1894.

8. AGE: Years: 53 Months: 4 Days: — If less than one day: hrs. min.

9. Birthplace: Gambrills - Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

MOTHER FATHER

12. Name: James Russell

13. Birthplace: Gambrills - Md

MOTHER

14. Maiden name: Elizabeth Tydeles

15. Birthplace: Pennsylvania

16. Informant: Roland Rawlings

Address: Gambrills, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 17, 1947 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Davidsonville

18. Funeral director: J. B. Johnson

Address: Annapolis, Md.

19. August 17, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14, 1947, at 4.20 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 8, 1947, to Aug. 14, 1947

and that I last saw h... alive on Aug. 14, 1947

Immediate cause of death: Uremia Coma — DURATION: Since 8/8/47

Due to: Chronic Interstitial Nephritis — 5/30/47

Due to: Diabetes Mellitus — 6 Yr.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.

M. D. or other

Address: Annapolis Md. Date signed: 8/14/47

VS/A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06714

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
County: Anne Arundel
City or town: Pen Lent
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Centerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Albert E Richards

3.(b) Social Security Number: 216-07-9285

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Christine Robinson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 29-1911

8. AGE: Years 36 | Months 3 | Days 24 | If less than one day: hrs. min.

9. Birthplace: Hamstead, Maryland
(Town, county, and state)

10. Usual occupation: chauffer

11. Industry or business: interState Transport

FATHER
12. Name: Edward L. Richards
13. Birthplace: Md

MOTHER
14. Maiden name: Estey Rupp.
15. Birthplace: Md

16. Informant: Mrs Edw L. Richards
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27/47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto, Md

18. Funeral director: Edward Tipton
Address: Hampstead Md

19. 8-27-47 (Date rec'd by registrar) 19 47 L. a. Bleet Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 1947 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~but I attended deceased from~~ Postmortem Examination Aug. 23 1947
~~and last saw h[illegible] alive on~~

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to:	
Coronary Sclerosis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or Other
Address: Annapolis Md Date signed: 8/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

66715

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Hannarlee Beach, Brooklyn 25 Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hours
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Castlewood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sterling O'Dell Salyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 1, 1921

8. AGE:

Years	Months	Days	If less than one day
26	4	20	hrs. min.

9. Birthplace: Dante, Russell Co. Va.
(Town, county, and state)
10. Usual occupation: Sales Manager
11. Industry or business: General Store

FATHER
12. Name: Marion M. Salyers
13. Birthplace: Russell Co. Va.

MOTHER
14. Maiden name: Elsie Sexton
15. Birthplace: Russell Co. Va.

16. Informant: J. G. Hale Jr.
Address: 104 Virginia St. Kingsport, Tenn.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug 24, 1947
(month) (day) (year)
Cemetery or crematory: Temple Hill
Location: Castlewood, Va.

18. Funeral director: Thomas W. Kingston
Address: Glen Burnie Md.

19. 8/22 1947 M. E. DeAlton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21, 1947 at about 5 15 A. M

21. I CERTIFY that death occurred on the date above stated. Pronounced
Post mortem Examination
Aug 21 1947

Immediate cause of death	DURATION
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Aug. 21, 1947
Where did injury occur? Hannarlee Beach (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Furnace Creek
Means of injury Drowning Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed 8/24/47

VS A10 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Anne Arundel
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Anne Arundel
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cedar Hill Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles E. Sheppard.

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Late Sarah Sheppard
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 19, 1877.
8. AGE: Years 79 Months 6 Days 5 If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore City, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Brick-Yard
FATHER 12. Name: Fred. Sheppard.
13. Birthplace: Germany.
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: George Sheppard.
Address: Cedar Hill Lane, Brooklyn Pk. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 7/47 (month) (day) (year)
Cemetery or crematory: Western Cem.
Location: Edmondson & Longwood
18. Funeral director: Harry A. Wilkes
Address: 4101 Edmondson Ave
19. Aug 6 19 47 (Date rec'd by registrar) C. A. Nelson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 5 19 47 at 8 30 A M
21. I CERTIFY that death occurred on the date above stated: Post mortem Examination
Aug. 5 19 47

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Chronic Myocarditis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or Other
Address: Annapolis, Md Date signed 8/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Johnson

06717

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
48 College Creek Terrace
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 48 College Creek Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war 1 war

3.(a) FULL NAME John Henry Simms

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed or divorced: married
6.(b) Name of husband or wife: Elizabeth Simms
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 26 1897
8. AGE: Years 50 Months 8 Days 17 If less than one day ..... hrs. ..... min.
9. Birthplace Annapolis (Town, county and state)
10. Usual occupation U. S. N. A.
11. Industry or business
FATHER 12. Name John Simms
13. Birthplace A. A. Co.
MOTHER 14. Maiden name Mary E. Miller
15. Birthplace A. A. Co.
16. Informant Elizabeth S. Simms
Address 48 College Creek Terrace
17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug. 11 47 (month) (day) (year)
Cemetery or crematory National
Location Annapolis
18. Funeral director J. B. Johnson
Address Annapolis
19. Aug. 11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 1947 at 6.50 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 Aug. 1947 to Aug. 7, 1947
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Cardiac Failure	
Due to: Hypertensive Cardio-Vascular Disease	2 1/2 Mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Theodore H. Johnson M.D.
M. D. or other
Address 70 Northwest Street Date signed 8/11/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


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06718

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1258

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 yrs.
Hospital, institution or street address where death occurred:
18 Shrine Court
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 18 Shrine Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maggie Simpson

3.(b) Social Security Number: None

4. Sex: F
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: William Simpson
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): April 1885
8. AGE: Years: 62 Months: Days: If less than one day: hrs. min.
9. Birthplace: Mt Talor A.A. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None
FATHER 12. Name: Steven Queen
13. Birthplace: Mt Talor A.A. Co. Md.
MOTHER 14. Maiden name: Hannah Queen
15. Birthplace: Mt Talor A.A. Co. Md
16. Informant: Mabel S Trigg
Address: 18 Shrine Court Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-17-47 (month) (day) (year)
Cemetery or crematory: Bryen Hill
Location: West Street
18. Funeral director: Mrs Charles E Hicks
Address: 45 Northwest St. Annapolis
19. August 17 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13 1947 at 11:45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-13-47 19.. to 8-13-47 19.. and that I last saw h alive on 8-13-47 19..

Immediate cause of death	DURATION
Hypostatic pneumonia	
Due to: a stroke	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. T. Talley M.D. M. D. or other
Address: 17 Carroll St. Date signed 8-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06719

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital,

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Riva, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sylvan Shores
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

STEPHANIE ESTELLE SMISSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	

6.(b) Name of husband or wife:

8/18/47 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	0	12	____ hrs. ____ min.

9. Birthplace: Annapolis, Anne Arundel, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Charlie Thomas Smisson
13. Birthplace: Fort Valley, Ga.

MOTHER — 14. Maiden name: Ada Cecilia Kalnoske
15. Birthplace: Shenandoah, Penna.

16. Informant: Charlie T. Smisson
Address: Emergency Hospt. Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Aug 31st 1947
(month) (day) (year)

Cemetery or crematory: St Stanislaus Cemt.

Location: Shenandoah Penn.

18. Funeral director: John M. Sayler. Son

Address: Annapolis Md.

19. Aug 31 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 19 47 at 5:44 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 19 47, to August 30 19 47 and that I last saw her alive on ____ 19____

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Cerebral Hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Ernest R Uhoeller
M. D. or other

Address: U. S. Naval Hospital Annapolis, Md. Date signed 8/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

66720

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 36 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Florence M. Tilghman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Teuch T. Tilghman
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): November 22nd 1874

8. AGE:

Years	Months	Days	If less than one day
72	8	14	____ hrs. ____ min.

9. Birthplace: Annapolis - A.A.Co. - Md.
(town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: Robert W. Milligan
13. Birthplace: Philadelphia, Penn.

MOTHER
14. Maiden name: Sarah A. Du Bois
15. Birthplace: Annapolis, Maryland

16. Informant: Mr. Teuch T. Tilghman
Address: 36 Maryland Ave. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/8/47 (month) (day) (year)
Cemetery or crematory: Naval Academy Cemetery
Location: Annapolis, Maryland

18. Funeral director: John M. Taylor & Son
Address: Annapolis, Maryland

19. Aug. 8 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 August 1947 at 5:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 July 1947 to 6 August 1947 and that I last saw h[illegible] alive on 6 Aug 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	14 days
Due to: arteriosclerosis	Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Donald H. Hunter, M. D.
M. D. or other
Address: 53 Cornhill St. Date signed: 8 Aug 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M.A. Richardson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

06721

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Rural, Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Mayo (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Susie Ellen Tilghman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1928

8. AGE: Years	Months	Days	If less than one day
26	7	9	hrs. min.

9. Birthplace: Mayo, A.A.Co., Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: Eugene Tilghman
13. Birthplace: Md.
MOTHER 14. Maiden name: Lottie Brown
15. Birthplace: Md.
16. Informant: Eugene Tilghman
Address: Mayo, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 5, 1947 (month) (day) (year)
Cemetery or crematory: Hopes Chapel
Location: Mayo, Md.
18. Funeral director: J.B.Johnson
Address: Annapolis, Md.
19. August 5 1947 (Date rec'd by registrar) Edward A. Leman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1st 1947, at 7:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947, to August 1, 1947, and that I last saw her alive on July 28 1947
Immediate cause of death: Acute Myocarditis — DURATION: 2 Days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other
Address: 150 - Clay St., Camden Date signed 8/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06722

1860 B

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH
County: Anne Arundel
City or town: Sparrows Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? several years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1004 Columbia Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frank Tolson
3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	married

8.(b) Name of husband or wife:
Sep. 19 [illegible] 6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) Sept. 19, 1915

8. AGE: Years	Months	Days	If less than one day
31			hrs. min.

8. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business
FATHER 12. Name: Frank B. Tolson
FATHER 13. Birthplace: Va.
MOTHER 14. Maiden name: Emiela Collins
MOTHER 15. Birthplace: Md
16. Informant: Mrs. Emiela Tolson
Address: 1014 Col. Rd. N.W.
17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug 11 1947 (Month) (day) (year)
Removal
Cemetery or crematory
Location: Washington D C
18. Funeral director: Robert G. McGuire
Address: 1820 9th St N.W. Washington D.C.
19. Aug 11 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 1947 at 2 00 P.M
21. I CERTIFY that death occurred on the date above stated: the cause of death was from
Postmortem Examination
and the chief symptoms were Aug. 10, 1947

Immediate cause of death	DURATION
Fracture of neck	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause from which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8/10/47
Where did injury occur? Sparrows Beach A.A. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Chesapeake
Means of injury: dove in shallow water Was injury at work? No

23. SIGNATURE: John M. Claffe M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 8/11/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

067238

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 7 months, 9 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Maryland

How long in hospital or institution? 2 years, 7 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1030 N. Arlington Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

LUCY WATKINS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Major Watkins

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
52	?	?	...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Guy Taylor
13. Birthplace: Virginia

MOTHER
14. Maiden name: Jessie Colyer
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. B. (Burial, cremation, or removal. Which?) Date thereof 8-17-47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: A. A. Co.

18. Funeral director: Samuel W. Sullivan Jr.

Address: 1011 N. Arlington Ave. Balto.

19. 8/15/47 (Date received by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14th 19 47 at 8:47A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Janusry 5, 1945 19... to August 14 19 47

and that I last saw her alive on August 14 19 47

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us since May 15, 1946
Due to	
Due to	
Other conditions: Epilepsy With Psychosis	Known to us since Jan. 5, 1945

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... injured at work?

23. SIGNATURE: Jacob Langenheim M.D. M. D. or other

Address: ... Date signed ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06724 G

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 m. 13 d.
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or Institution? 7 m., 13 d.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1008 Vincent St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Grace Whitfield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	colored	widow

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Hospital records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 27-47 (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetery
Location: Baltimore City
18. Funeral director: Geo. B. Kelson
Address: 1303 Presstman St.

19. Aug 26 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 19 47 at 8 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 19 47 to Aug 23 19 47 and that I last saw h.. alive on Aug 23, 19 47

Immediate cause of death	DURATION
Generalized arteriosclerosis	
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: David Marguerite M.D.
M.D. or other
Address ..... Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06725

94a

B

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred:
Emergency
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: —
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3122 Northampton St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: William Wiener

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Helen Wiener
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 18, 1903

8. AGE: Years: 44 | Months: 1 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Buyer

11. Industry or business: Hecht Co.

FATHER
12. Name: HYMAN WEINER
13. Birthplace: RUSSIA

MOTHER
14. Maiden name: —
15. Birthplace: RUSSIA

16. Informant: Hospital Records
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 21 1947 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director: B Danzansky & Son
Address 3501-14th St N W

19. Aug. 21 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21 1947, at 1 30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 4 1947, to Aug. 21 1947 and that I last saw h. alive on Aug. 20, 1947

Immediate cause of death	DURATION
Ventricular fibrillation	
Coronary Occlusion	17 days
Due to: Coronary Occlusion	17 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D.
M. D. or other
Address: Annapolis, Md. Date signed: Aug. 21, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15